GOVERNOR DOYLE'S TASK FORCE TO IMPROVE ACCESS TO ORAL HEALTH
JANUARY 7, 2005
MEETING MINUTES
Revised and Approved

Members Present: Lori Barbeau, Bill Bazan, Stephanie Burrell, David Carroll, Blane Christman, Carl Eisenberg, Monica Hebl, Wendy MacDougall, Maureen Oostdik-Hurd, Midge Pfeffer, Graciela Villadoniga

At 10:00 am, the Chair of the Task Force, Dr. Blane Christman, called the meeting to order.

The minutes from the Dec. 10, 2004 meeting were revised and approved.

The meeting began with a presentation by Andy Snyder, Mary Laughlin, Robert Dwyer and Mark Moody of the Department of Health and Family Services on Medicaid funding for oral health.

Highlights of Presentation
The history and components of Medicaid and BadgerCare were defined followed by an overview of the programs including:

1) A description of covered services (what Medicaid will pay for), non-covered services, and non-billable, non-reimbursable services.
2) An explanation of payment types including fee-for-service, Federally Qualified Health Centers and Managed Care
    - Approximately 6,000 disabled individuals are covered under a small managed care program called Independent Care, or iCare. This program includes oral health services as a covered benefit.
    - The paid-to-billed ratio for fee-for-service claims was 46 percent in 2004, down from a recent high of 61 percent in 1993.
    - Wisconsin has 13 Federally Qualified Health Centers (FQHC) in qualified shortage areas. As required by federal law, they receive cost-based reimbursement for services provided to Medicaid recipients.
    - Medicaid reimburses physicians and HealthCheck providers for limited prevention services.
    - HMOs
        - Managed care is a way to guarantee access. In the four southeastern counties that include oral health in managed care contracts (Milwaukee, Waukesha, Racine, and Kenosha), HMOs are contractually obligated to maintain networks of dental providers that must be within 35 miles of clients and provide enrollees routine appointments within 90 days or emergency appointments within 24 hours.
        - Each contracted organization must submit, annually, their provider network. If they lose a provider during the contract, they must notify the Department so DHFS can evaluate the impact of the loss. An audit was done in 2004 to confirm these providers were part of the HMO network.

- HMOs must maintain outreach program to make clients aware of the services that they provide. HMO enrollees also have access to advocates, an Ombuds program, and several grievance procedures.

3) Some data about dentist participation in Medicaid,

- 40 percent of Wisconsin licensed dentists submitted a fee-for-service claim in 2004.

4) A breakdown of expenditures and payments,

- $28 million of expenditures are paid as fee-for-service claims. Managed care payments amount to approximately $10 million.
- Raising fees to the 75th percentile would approximately double the cost of the Medicaid dental benefit. Assuming that utilization would rise to commercial levels as more dentists accept MA patients, the cost could rise to over $150 million.
- Indiana increased funding to the 75th percentile and the number of dentists submitting claims grew. Coverage of Medicaid clients may not have been as high as expected. Michigan also saw an increase in dentist participation in the counties where they increased reimbursement. Because of cost considerations, Michigan removed adults from coverage and did not make the program statewide.

5) An update on the current billing procedures and paperwork,

- Prior Authorization: Currently, a two-page prior authorization (PA) form needs to be submitted. The Department plans to reduce the number of services that require prior authorization. The Department is also working to replace the PA cover sheet with the ADA claim forms.
- Eligibility: It is important for providers to verify recipients' eligibility prior to delivering service because (1) not all recipients (like those in the tuberculosis and Family Planning Waiver programs) have a dental benefit and (2) a person presenting a Forward card may not have Medicaid eligibility on a particular day.
- Federal Requirements: Some, but not all of the administrative complications are driven by federal requirements of uniform transactions and the fact that Medicaid is the payer of last resort.
- The Department's goal, under the new fiscal agent contract, is to develop an Internet claims process that will immediately alert filers to errors.

6) Information about how recipients access care and obstacles to that access, and

7) A summary of the Department's response to issues limiting access.

After a break, the Task Force heard from Dr. Mike Donohoo, representing the Wisconsin Dental Association on their five recommendations to improve access to oral health care in Wisconsin.

1. Fund reimbursement at the 75th percentile.
    - State needs to determine what priority it is going to place on oral health and then fund it.
2. Streamline Medicaid paperwork to make it more like commercial insurance.
    - The form is better than it was but the Department needs to keep working to simplify and improve this process.

3. Set up triage mechanism to identify children most in need of restorative care.
    - Need the state to define where the demand is.

4. Report and document the success of sealants and fluoride varnish programs.
    - Monitor our programs. Make sure that we are getting the "bang for our buck" so that we spend our money wisely.
5. Seek funding from Blue Cross and Blue Shield for oral health proposals.

Key points:

1. Don't develop a two-tiered dentistry system – one for the haves and one for the have-nots.
2. Lessening the process for foreign-trained dentists to receive licensure puts individuals in Wisconsin at risk.
3. Prevention is only a piece of the issue. Prevention programs on their own will not solve the problem.
4. Private practice dentists need to be part of the solution
5. Support the tax on soda, "Two Cents for Tooth Sense."

If these items are worked on seriously, we can move a long way in answering the issue of children needing care.

Eisenberg Question: HMOs have subcontracts. Why doesn't the state contract directly with the subs?
Moody Answer: HMOs give us risk contracts and guarantee service. The Department (Medicaid) should resume a regular meeting schedule with WDA and other interested parties so that we can have continued dialogue on oral health issues. We cannot solve the access problem with one simple solution so we need to work with the dentists and others on incremental solutions that take us where we want to be.

Oostdik-Hurd: Services that used to be bundled should not be separated out as a stand-alone bill where the service is not reimbursed.

Doral Dental: Agree that funding and fee levels are lower in Wisconsin and they have experienced some trouble recruiting dentists. They have a low administration fee so dentists actually get the funds contracted for oral health services.

UnitedHealthcare: Working to increase the percentage of Medicaid patients who get in to see a dentist above 30 percent. Using postcards and emergency room surveys, they have increased to 35 percent over the last six months.

Hebl Questions: Even though we have a guarantee of coverage, how does the state know that services are being delivered? What is the capitation fee? What parts are covered? What amount of contract funds is used before a dentist sees a patient (administrative costs)?

Part of Monica's questions were answered by Mark Moody: In part, private dentists that are not getting a fair rate of return on the services they provide need to re-negotiate their contracts with the HMOs. Think of managed care as "what are you buying?" Currently, the state is buying access. The contracts have an added value because HMOs are required to provide dental care. The Task Force may want to consider the question of "what we are buying" if they want to change the focus.

MacDougall Question: Identified under the HealthCheck procedure is the requirement that if we have Medicaid, we must have oral health programs for individuals under the age of 21.
Moody Answer: The federal requirement is that the state has to **cover** the service – finding the service has been and continues to be the challenge. There have been lawsuits closely related to this issue in other states saying that the state has not lived up to its requirement.

MacDougall: Money distribution is a challenge that we may not be able to control. In my area, we are working together with private dentists to come up with solutions. Part of that solution is prevention with education and public information.

Barbeau Questions: Number of individuals covered under HMOs. Number of sub-contracted providers and which ones provide only emergency care.
Answer: 166,403 individuals covered. Networks do not permit emergency-only providers.

Eisenberg: Compare HMO providers with fee-for-service. What access percentage are we getting from HMOs? Is it adequate?
Oostdik-Hurd: Consider outsourcing MA to someone other than EDS. What happened to pilot program to separate out oral health?

Moody Answer: Actually, the HMO contracts are a pilot that separates Medicaid out from EDS. As to services by EDS, if there is a problem, we are responsible for answering those concerns since we determine the services provided by all of our contracted vendors. When we re-bid the contract for a Medicaid provider, we invited vendors to build consortia to cover services statewide. We allowed companies to carve out pieces.

Hebl: When other states have increased access, they have made oral health a financial commitment. We need to involve resources in our discussion. $112 million is small when considered in light of the full state budget.
Welsh and Moody Answer: We do not oppose increased reimbursement but the Department is under budget constraints in all of our programs, all of which are fighting for funding.

Dwyer and Moody then answered some concerns about Medicaid paperwork: The Department will continue to make improvements. We need to simplify the process especially for dentists who do not make regular claims. We need to make the prior authorization process more like a commercial insurance process. We could use some input from dentists on if they would like prior or post authorization? If they are going to provide a specific service, we may be able to define a list of specific services covered. The special handling unit that used to exist was not cost effective but when we get a specific complaint, we do what we can to handle it or change the system.

Pfeffer: The current policy for HealthCheck regarding age of first dental visit is age 3, which is not the current policy of the ADA or the AAPD.
Snyder: We would need to change the Administrative Code to make that change but our dental code covers before age 3.

Pfeffer: Michigan model covers only a small percentage of the total population (48 counties).

Doral: The Tennessee model doubled access and doubled the number of participating dentists and covers about 48% of Medicaid eligible kids.

Bazan: Reality Check: With a $800,000 deficit, I'm not sure that we can get increases. There are other do-able things that do not cause further strain on the budget.

Barbeau: How do we know that HMOs are living up to the guarantees of service? Are our contracts enforceable if we do not know what services are being provided?
Moody: We will get members information from our surveys of clients.

Villadoniga: We need to get updated provider lists from HMOs monthly so that pediatricians know how to get access and who is available. We need to do a better job at linking medical doctors and oral health providers.

At the end of the meeting, the Task Force prepared for the January 14th meeting where we will discuss models from other states and start to focus on developing possible strategies to improve oral health access.

The Task Force adjourned the meeting at 2:00 p.m. The next meeting of the Task Force will be Friday, January 14th at the Madison Public Health Department. The meeting will be extended by one-half hour and start at 9:30 am.